STATE OF MAINE
SUPREME JUDICIAL COURT

LAW DOCKET NO. CUM-18-445

CAROL A. KENNELLY
Plaintiff/Appellee

v.

MID COAST HOSPITAL
Defendant/Appellant.

AMICUS BRIEF OF THE MAINE HOSPITAL ASSOCIATION AND MAINE MEDICAL ASSOCIATION

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STATEMENT OF INTEREST OF AMICI CURIAE

The Maine Hospital Association ("MHA") represents 36 community-governed hospitals in Maine. MHA's mission is to provide leadership through advocacy, information and education and to support its hospital members in fulfilling their mission to improve the health of their patients and communities they serve. MHA is a leader in developing health care policy and works to stimulate public debate on important health care issues that affect Maine's citizens.

The Maine Medical Association ("MMA") is one of fifty state medical societies that make up the American Medical Association. MMA's mission is to support Maine physicians, advance the quality of medicine in Maine and promote the health of all Maine citizens. MMA is recognized throughout Maine as an expert on healthcare, healthcare delivery, and potential healthcare threats to the citizens of Maine.

MHA and MMA have significant interests in this case, which involves the circumstances under which hospitals and doctors may be required to disclose personal health information to individuals not otherwise authorized to receive such information. Today, hospitals and doctors possess vast and ever-increasing amounts of personal health information about their patients. Applicable law and ethical standards require doctors and hospitals to guard against the disclosure of that information. The production of third-party personal health information will

undermine the objectives of the laws that require confidentiality in the first place. It will also place significant administrative and legal burdens on doctors and hospitals. The impact on the health care system could be significant: doctors and administrators will even more over-burdened and patients will lose confidence in the doctors and hospitals that treat them. For those reasons, MHA and MMA submit this brief to urge the Court to reverse the Superior Court's decision.[1]

SUMMARY OF THE ARGUMENT

For the second time in one year, this Court is asked to consider whether the legal claims of a medical malpractice plaintiff outweigh the significant and statutory privacy interests of individuals who have no connection with that malpractice claim. The first time this issue was presented, the Court declined to reach the merits, holding that the underlying Superior Court decision that held the third-party medical records were discoverable was "a nullity" and therefore not appropriate for consideration. *McCain v. Vanadia,* 2018 ME 118, ¶ 12. Dissenting, Justice Alexander warned that the Court's failure to address the merits would "invite others to launch similar fishing expeditions, hoping to bolster a

[1] Appellant also seeks reversal of the Superior Court's order requiring that they produce the treating physician's personnel file. Amici's brief is confined to the issue of discoverability of third-party medical records, although Amici agree that any documents protected by a statutory or common law privilege should be immune from discovery.

client's case by prying into the private medical records of perhaps hundreds of innocent, unaware individuals." *Id.* ¶ 20.

Justice Alexander's warning was prescient. Less than two months after the Court issued its decision in *McCain*, the Superior Court issued the order on appeal here (the "Order"), which required Appellants to produce the medical records of 50 individuals with no stake in, and likely no knowledge of, Appellee's claims. The Court should now answer the question presented — whether, by redacting certain identifying information from medical records, those records lose the protections afforded by the physician-patient privilege and federal and state privacy laws — and should answer it in the negative.

In reaching the opposite conclusion, the Superior Court committed a significant error. First, the Superior Court erred in concluding that, once redacted, health care records no longer constitute "health care information, "individually identifiable health information," or privileged communications. Second, the Superior Court failed to give due consideration to the fact that individuals can be identified from their health care records even with obvious identifiers redacted, especially in rural states like Maine. Third, the Superior Court wrongly concluded that redaction addresses the privacy interest that patients have in the health information they share with their doctors. Patients who find that their most private medical information was shared with individuals with whom they have no

relationship and for purposes they may or may not endorse will be justifiably concerned, even if that information cannot be traced directly back to them. They will be similarly concerned to learn that the information was shared without having received notice or an opportunity to be heard. In short, the Superior Court's ruling is inconsistent with the language, purpose and spirit of the physician-patient privilege and the privacy laws.

Moreover, the reasoning and holding of the Superior Court's Order will place significant and unjustified burdens on already over-worked doctors and health care administrators. First, doctors and hospitals will be required to collect and painstakingly redact large numbers of medical records — including electronic health records containing enormous amounts of data and other information from numerous sources. Second, doctors and hospitals can face significant liability should they inadvertently produce personally identifying information, a not unlikely scenario given the volume of documents and the numerous categories of information that must be redacted. Finally, it will require that doctors choose between their professional obligations —which require that they fiercely guard patient confidences — and contempt of court.

As Justice Alexander recognized, the "implications of the Superior Court's ruling for patients and the medical community that serves those patients are vast." *McCain*, 2018 ME 118, ¶ 23. Left to stand, a ruling that third-party medical

records are discoverable will erode patients' confidence in their relationships with their doctors and in the health care system as a whole, which one might argue is already taxed. It will place significant burden and expense on hospitals and doctors. These costs and burdens will necessarily be passed to patients, insurance companies and taxpayers. The Court should reverse the Superior Court's Order. It is contrary to applicable law and common sense and will have a significant and negative effect on the health care system in this state.

BACKGROUND

This appeal arises out of a malpractice action relating to gallbladder surgery performed by Dr. Mia Marietta at Mid Coast on September 2, 2015. (A.19.) According to the Appellee, Dr. Marietta negligently transected her common hepatic duct while performing the surgery. (*Id.*) Appellee claims that Mid Coast is vicariously liable for Dr. Marietta's negligence. (A.20.)

The central issue in this medical malpractice action is whether Dr. Marietta should have obtained what is commonly referred to as the "critical view of safety" ("CVS") before attempting to remove Appellee's gallbladder. (A.27.) Appellee claims that it has become the consensus view among surgeons and the standard of care to first obtain the CVS. (*Id.*)

Dr. Marietta disagrees. She concedes that she does not use the CVS approach when performing gallbladder removals. (A.28.) Instead, she uses an

approach that she developed over many surgeries to identify the cystic duct and insure that it is the cystic duct before transecting it. Dr. Marietta's operative notes reflect that she used this approach, as opposed to the CVS approach, while performing Appellee's cholecystectomy. (A.19.)

The issue, then, is not whether Dr. Marietta used the CVS approach in performing Appellee's surgery — she concedes that she did not — but whether the CVS approach represents the standard of care such that Dr. Marietta's decision to use a different approach constitutes medical malpractice. That issue, it seems obvious, is one for experts to battle over. Additional evidence to substantiate that Dr. Marietta uses a different approach is irrelevant, given that Dr. Marietta has conceded that fact. Nonetheless, Appellee served Appellant with document requests seeking the redacted operative notes of fifty non-party gallbladder removal surgeries, Dr. Marietta's personnel file and documents relating to Dr. Marietta's training and continuing medical education, among other documents. (A.6.)

Appellee claimed that the operative notes are relevant for purposes of determining whether the approach Dr. Marietta used in Appellee's surgery is consistent with the approach she used in other surgeries and whether Dr. Marietta has used the CVS in any other cholecystectomies. Appellee claims that the personnel file and training documents are relevant to determining whether Dr.

Marietta was terminated or disciplined by Mid Coast for substandard or negligent care and whether Dr. Marietta was trained on the CVS approach to cholecystectomies. (A.23-26.)

Appellant objected to the document requests on the grounds that the documents were subject to doctor-patient privilege and/or confidential under federal and state laws. Appellant argued that the operative notes were protected by the Health Insurance Portability and Accountability Act ("HIPAA") and 22 M.R.S. § 1711-C and that the training documents were protected by the Maine Health Security Act. (*Id.*)

Appellee moved to compel production of the documents over Appellant's objections, and the Superior Court granted Appellee's motion. (A.27-41.) Relying heavily on the Penobscot County Superior Court's decision in *McCain v. Vanadia*, PENSC-CV-2016-117, 2017 WL 7048289 (Me. Super. Ct., Penobscot Cty., Aug. 7, 2017) (the "Order"), the Superior Court held that, once redacted to remove patient identifiers, the operative notes were no longer protected by the doctor-patient privilege or state or federal health privacy laws. The court also held that the personnel file and training and continuing education documents were discoverable unless particular documents within those files fell within a specific privilege or were created for a professional competence review activity.

This appeal followed.

ARGUMENT

I. THE SUPERIOR COURT'S DECISION IS INCONSISTENT WITH THE DOCTOR-PATIENT PRIVILEGE AND STATUTORY PRIVACY PROTECTIONS.

Physicians, hospitals and other health care providers are required by law to protect the personal health information of their patients. The existence of that obligation and the protection it affords have become an integral part of our healthcare system and patients' health care experiences: with every doctor visit, the patient is reminded of the sanctity of his or health care information, be it with privacy forms and notices, the precautions now taken to shield records from view of others visiting the doctor's office, or the fact that discussions no longer occur in waiting rooms or hallways.

The obligation to protect the confidentiality of health care information is codified in various places, including in statutes and Maine Rule of Evidence 503 – – the physician-patient privilege. *See Halacy v. Steen*, 670 A.2d 1371, 1376 (Me. 1996) (addressing privilege in the context of a report of a presentence investigation). It is also part of the Hippocratic oath and the American Medical Association's Code of Medical Ethics. Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (1943); American Medical Association Code of Medical Ethics, available at https://www.ama-assn.org/delivering-care/ama-code-medical-ethics.

The purpose of the privilege is long-recognized. First, it encourages patients to disclose all information that may aid in their treatment and diagnoses by eliminating the fear of disclosure of "embarrassing private details concerning health and bodily condition." 1 McCormick on Evid. § 98 (7th ed.). Second, it promotes individual autonomy by giving the patient, and not the doctor, the power to decide who will receive information regarding his or her health. *See* Edward J. Imwinkelried, The New Wigmore: A Treatise on Evidence, Evidentiary Privileges 13 (2002); I.B. Abdalrahman et al., Autonomy and Confidentiality: Patients' Perspectives, Tropical Doctor (2017). Patient autonomy is critical to insuring "the right of the patient to determine the nature of his or her own medical care," a right recognized by this Court to be of "central importance" in our legal tradition. *In re Gardner*, 534 A.2d 947, 950 (Me. 1987) (quoting Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 7 (1987)).

So significant is the impact of unauthorized disclosure of personal health information that the Maine legislature, along with legislatures across the country and the U.S. Congress, have enacted strict laws requiring that hospitals, doctors and other individuals and entities in possession of personal health information guard against that information's disclosure. Maine law provides that "[a]n individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility" except under

certain specified circumstances, none of which are present here. 22 M.R.S. § 1711-C(2).[2] The federal statute — the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") — similarly protects against the unauthorized disclosure of health care information. *See* 42 U.S.C. § 1320d–6; 42 CFR pts. 160, 164. The purpose of HIPAA is to "provide all Americans with a basic level of protection and peace of mind that is essential to their full participation in their care." 65 Fed. Reg. at 82,464. Indeed, the Department of Health and Human Services, in enacting regulations to fulfill HIPAA's mandate, noted:

> The provision of high quality health care requires the exchange of personal, often-sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient's ability to trust that the information shared will be protected and kept confidential. Yet many patients are concerned that their information is not protected. Among the factors adding to this concern are the growth of the number of organizations involved in the provision of care and the processing of claims, the growing use of electronic information technology, increased efforts to market health care and other products to consumers, and the increasing ability to collect highly sensitive information about a person's current and future health status as a result of advances in scientific research.

Id. (emphasis added).

[2] "Health care information" is defined as "information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual."

This guidance steers the Court in a single direction — that the confidentiality of health care information must be fiercely guarded. The Superior Court's decision represents a significant departure from that guidance, a potentially critical breach in the overall privacy rights of individuals and, perhaps, the beginning of an alarming trend within Maine's courts. Pursuant to the Superior Court's Order and reasoning, personal health information, once redacted to remove identifying information, loses its privilege and confidential nature. The decision undermines both the purpose and terms of the privilege and statutes protecting the confidentiality of personal health information. Indeed, it does more than that. It "authorizes [plaintiff] and her attorney to launch a fishing expedition, reviewing the medical records of at least [fifty] other innocent, unrelated individuals who have undergone similar procedures." *McCain*, 2018 ME 118, ¶ 20

Justice Alexander recognized these concerns in his dissent in *McCain v. Vanadia*, 2018 ME 118. In *McCain*, the Court was asked to address the very issue presented by this appeal — whether patient records, once redacted, lose the confidentiality protections afforded by state and federal privacy laws and the physician-patient privilege. The Court declined to address the merits of the issue, holding that the Superior Court's decision compelling disclosure of redacted patient records was a nullity. *Id.* ¶ 13. In a strongly worded dissent, Justice Alexander argued that the Court should have addressed the merits of issue

presented, and that the Superior Court's decision should be reversed. Justice Alexander rightly recognized that the Superior Court's decision in that case — like the Superior Court's decision here

> authorizes review of records of unnamed and unnotified patients in violation of those patients' constitutional rights to privacy, in violation of privileges established in our Rules of Evidence, and in violation of numerous state and federal statutes mandating the privacy of patient identifies and the confidentiality of patient records.

2018 ME 118, ¶ 21.

First, as recognized by Justice Alexander, the Superior Court's decision is inconsistent with the obligations placed on doctors and hospitals by 22 M.R.S. § 1711-C and HIPAA. Under Section 1711-C, medical providers must maintain the confidentiality of information that "directly identifies the individual." Under HIPAA regulations, information is confidential so long as it "identifies the individual" or "can be used to identify the individual." While the Superior Court's Order provided that the records be redacted to remove "identifying information (name, dob, age, sex, race)," (A.16 (Order at 12)), that sort of identifying information is not the only information that can be used to identify a patient, especially in a rural state like Maine. Indeed, in a small town, records indicating the treating physician, the type of procedure and the date of the procedure — the very information that the Superior Court ordered disclosed below — may be sufficient to identify the patient. Justice Alexander recognized that in such

communities, "the likelihood of actual confidentiality of identification of patients . . . would be uncertain." *McCain*, 2018 ME 118, ¶ 27.

The Superior Court also recognized the dangers associated with the disclosure of redacted medical records in rural states like Maine, but rejected them on the grounds that a single rural state —South Dakota — has permitted the disclosure of redacted records. (A.11(Order at 7).) In fact, the case relied upon by the Superior Court, *Wipf v. Altstiel*, 888 N.W.2d 790, 795 (S.D. 2016), reverses and remands the lower court's decision permitting the disclosure of redacted medical records on the grounds that the lower court failed to consider that the counties in which the plaintiff received the medical services at issue "have small populations, which could lead to identification of a patient." The *Wipf* court ordered the lower court to consider whether, in light of the rural population, "additional safeguards will ensure patient anonymity." *Id.*

Moreover, redaction does not exempt otherwise privileged communications from the protections of the physician-patient privilege. Rule of Evidence 503(b) provides that "a patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications made for the purpose of diagnosing or treating the patient's physical, mental or emotional condition." Thus, Rule 503 protects the communication itself and not, unlike certain of the statutory provisions, merely the personal identifying portions of the

communications. The Superior Court's conclusion that redaction of personal identifying information exempts communications for the protection afforded by the privilege is inconsistent with the language of the privilege itself.

Second, the Order fails to serve the purpose of the privacy laws or the physician-patient privilege because it will erode patient confidence in the privacy of the information they share with their physicians. The Superior Court's Order undeniably requires the disclosure of private health information. While, at least in some cases, it may not be possible to trace that information to a particular person, that is likely of little significance to the person to whom that confidential information belongs. The privacy protections that exist understandably lead patients to believe that information shared with their physicians will be carefully and unequivocally guarded. Indeed, Maine law requires that doctors and hospitals provide their patients with "notice of the right of the individual to control the disclosure of health care information." 22 M.R.S.A. § 1711-C(7). For that reason and others, patients surely do not understand that the information they share with their doctors can be publically disclosed as long as certain facets of that information are removed. Under the precedent established by the Superior Court's Order, a patient could find a description of his or her doctor visit in a publically-available document or thereafter discussed at a publically accessible trial. Even

without identifying information attached, the patient will likely find the disclosure of his or her most personal information deeply concerning, if not shocking.

Third, application of the Superior Court's Order will undermine patient autonomy, another central objective of privacy laws. Under the Order and the precedent it sets, patient records will be produced without any authorization from or notice to the patient. Indeed, the patient is completely cut out of the disclosure process — the patient is given no opportunity to object to the disclosure of his or her health information or to the scope of redactions. This fact is especially problematic and significant because the physician-patient privilege belongs to the patient, not the physician. Yet under the Superior Court's order, the patient is given no voice.

The impact of this breach in the confidentiality of patient medical information could be significant. Patients who fear that their medical information will be disclosed may be less likely to seek medical care. The results of physician avoidance are significant and included delayed diagnosis and treatment, generally at a significantly higher cost than if the medical issue had been addressed earlier. The failure to seek early and prompt medical treatment can also limit the treatments available to physicians, sometimes resulting in permanent injury. Moreover, patients who fear that their medical information will be disclosed might see their doctors, but be less forthcoming with the information they share, thereby

limiting the doctor's ability of the doctor to diagnosis and treat his or her patient. V. Kannan and P. Veazie, Predictors of Avoiding Medical Care and Reasons for Avoidance Behavior, Med. Care 336 (Apr. 2014). Finally, patients who question the confidentiality of their medical information may be less likely to participate in medical studies or other health care initiatives.

There are other impacts as well. Patients who learn that their medical information has been disclosed in a malpractice action might suspect that their medical care was deficient, potentially increasing the number of malpractice claims. It will also likely encourage patient demand for their own medical records, so that they can view all the information included therein. As discussed further below, the cost associated with producing such records and the associated burden on doctors and hospitals is significant.

The Superior Court below, like Justice Alexander in his dissent in *McCain*, correctly noted that a number of decisions from courts outside of Maine have compelled the production of redacted medical records, reasoning that the physician-patient privilege and/or statutory protections do not apply. (A.9-10 (Order at 5-6); *McCain*, 2018 ME 118, ¶¶ 31-33.) However, other and better reasoned decisions have held that the privilege and statutory protections bar disclosure of even redacted records. *Buford v. Howe*, 10 F.3d 1184, 1189 (5th Cir. 1994), is directly on point. In *Buford*, just like in the proceeding below in this

matter, the plaintiff sought the medical records of patients on whom the defendant physician performed similar surgeries in order to address the physician's practice in performing such surgeries. The District Court quashed the plaintiff's subpoena and the Fifth Circuit affirmed. The court held that the records were privileged "even though identifying information was deleted" because they were "clearly derived by virtue of the professional relationship between the patient and the doctor." *Id. See also, e.g., Peronis v. United States,* No. 2:16-cv-01389, 2017 WL 3705058 (W.D. Pa. Aug. 28, 2017) (holding disclosure of redacted medical records of other patients violated the physician-patient privilege and Pennsylvania statutes); *Glassman v. St. Joseph Hosp.*, 631 N.E.2d 1186, 1198-99 (Ill. App. Ct. 1994) (holding production of redacted medical records of other patients would violate physician-patient privilege).

In sum, the Superior Court's Order is inconsistent with the statutory and common law protections that apply to personal health information. Left to stand, the Order could significantly and negatively impact patients' confidence in their relationships with their physicians and, ultimately, in the health care they receive.

II. EXTENSION OF THE SUPERIOR COURT'S DECISION WILL PLACE AN UNREASONABLE BURDEN ON HOSPITALS AND DOCTORS.

Although the Order on appeal was decided in the context of the particular facts of appellee's malpractice claim, the Superior Court's Order has broad

application and far-reaching consequences for doctors and hospitals. Upholding the Superior Court's decision will, almost undoubtedly, usher in a new standard practice in medical malpractice cases — the demand for third-party medical records. Justice Alexander predicted just such a result in *McCain*, noting that "once he door is opened, access to other patients' records may be obtained by complainants unhappy with all manner of treatments, including, as a few examples, abortions, HIV infection therapies or substance abuse treatments. *McCain*, 2018 ME 118, ¶ 25. Justice Alexander noted that, depending on the kind of procedure at issue, "[s]ometimes the invasion of rights or privacy and confidentiality of only a few patients may be involved, other times, with more common procedures, hundreds of records of other patients may be sought." *Id.* at ¶ 24.

Moreover, the extremely low relevance threshold imposed by the Superior Court, especially when coupled with the Superior Court's holding in *McCain*, will open the door to the discovery of third-party medical records in almost every case. In *McCain*, the plaintiff claimed that the third-party medical records were relevant to establishing the treating physician's pattern and practice, given that the physician testified that the operative notes for the procedure at issue did not reflect that pattern and practice. *McCain v. Vanadia*, No. CV2016117, 2017 WL 7048289, at *1 (Me. Super., Penobscot County Aug. 07, 2017). Here, no similar claim of pattern or practice was at issue and Dr. Marietta agreed that her operative

notes did reflect the steps taken during the procedure at issue. Nonetheless, the Superior Court found that third-party medical records relevant. With such a holding, it is difficult to conceive of a case in which a plaintiff cannot concoct some theory by which third-party medical records are relevant.

The burden and cost of producing those records will fall squarely on hospitals and doctors. They will be required to compile and then painstakingly redact the medical records to remove all potentially identifying information, and they will face liability should they — even inadvertently — produce identifying health care information, and they will find themselves in the untenable position of either defying a court order or violating their professional code of ethics. Ultimately, patients and health care consumers will feel this burden through higher medical costs and over-burdened medical providers.

The burden of producing such records, particularly on non-party physicians and hospitals, could be overwhelming. First, the era of contained, paper medical files is over. Many physicians and practices, and almost all hospitals, maintain their records in electronic form. These electronic records contain myriad pieces of information from multiple sources. Often, they can span thousands of pages — once reduced to paper form — for a single hospital stay. As anyone who has requested medical records can attest, production of such documents for one, let along numerous, patients is time and resource-consuming. This is largely due to

the way in which electronic medical records are maintained, which do not easily translate to paper documents. Printing of electronic medical records often requires the manual accessing of various tabs, fields, and drop down menus.

The redaction of the records to remove all personal identifying information is an even more onerous task. HIPAA alone identifies twenty-two categories of information that must be removed from records in order to "de-identify" them. *See* 45 C.F.R. § 164.514. These include addresses and any other geographic subdivision smaller than a state, account numbers, medical record numbers, dates of birth, admission or discharge and "any other unique identifying number, characteristic, or code." *Id.* The production and redaction of documents will have to be undertaken by administrative staff that is already over-burdened the demands of insurance company and Medicare and Medicaid reporting and billing rules.

Second, it is the hospitals and doctors, and not the individual requesting the records, who will face liability should protected health information be disclosed. The liability can be significant. Maine law provides for civil penalties of $5,000 to $10,000 for certain violations on top of all common law remedies, which are specifically preserved by statute. *See* 22 M.R.S. § 1711-C(13). HIPAA penalties can reach $50,000 for a violation, even where the producing entity "did not know and, by exercising reasonable diligence, would not have known" of the unlawful disclosure. *See* 45 C.F.R. § 160.404(b)(2). For parties, the potential imposition of

such fines may seem part and parcel of the risks of litigation. But for non-parties, the potential imposition of such fines is unjustified.

Finally, the Superior Court's Order puts doctors in the untenable position of having to choose between violating a court order and violating the Code of Ethics that binds them and the oath to which they swore. As discussed above, both the AMA Code of Ethics and the Hippocratic Oath identify patient confidentiality as one of a doctor's most important obligations. The Superior Court's Order asks that doctors ignore those obligations by disclosing information that their patients shared with them in confidence and with the understanding that that confidentiality would be maintained.

In sum, the reasoning and holding of the Superior Court's Order places an overwhelming and unjustified burden on hospitals and doctors. The costs of meeting that burden can be substantial, and will necessarily be passed along to patients, health insurers and the taxpayers. This Court can eliminate that burden and preserve patients' confidence in the physicians and hospitals by reversing the Superior Court's Order.

CONCLUSION

For the reasons stated herein, and in briefs of appellants, the Court should reverse the Superior Court's Order.

Date: February 11, 2019

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CERTIFICATE OF SERVICE

I hereby certify that, on February 11, 2019, I filed the original and two copies of this Amicus Brief of The Maine Hospital Association and Maine Medical Association with the Clerk of the Supreme Judicial Court and simultaneously emailed it in the form of a single text-based pdf file to lawcourt.clerk@courts.maine.gov, and served two copies by U.S. mail and email on each of the following.

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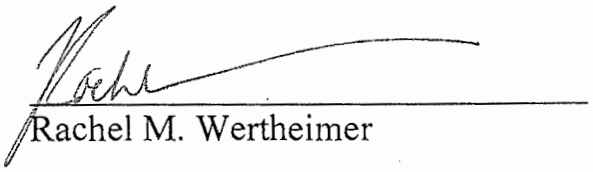

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